FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **North Carolina**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Nina Yeager, Director, Division Medical Assistance
NC Department of Health and Human Services
(Signature of Agency Head)

SCHIP Program Name(s): NC Health Choice for Children

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
X Separate Child Health Program Only
_____ Combination of the above

Reporting Period: ***Federal Fiscal Year 2002*** *Note: Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02.*

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Submission Date: **December 20, 2002**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility	From		% of FPL for **infants**		% of FPL	From	185	% of FPL for **infants**	200	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	From	133	% of FPL for children ages **1 through 5**	200	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	From	100	% of FPL for children ages **6 through 16**	200	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	From	100	% of FPL for children ages **17 and 18**	200	% of FPL
Is presumptive eligibility provided for children?		No				x	No			
		Yes, for whom and how long?					Yes, for whom and how long?			
Is retroactive eligibility available?		No								
		Yes, for whom and how long?				x	Yes, for whom and how long? To the first day of the month in which application was made			
Does your State Plan contain authority to implement a waiting list?	Not applicable						No			
						x	Yes			
Does your program have a mail-in application?		No					No			
		Yes				x	Yes			
Does your program have an application on your website that can be printed, completed and mailed in?		No					No			
		Yes				x	Yes			
Can an applicant apply for your program over phone?		No				x	No			
		Yes					Yes			
Can an applicant apply for your program on-line?		No				x	No			
	Yes – please check all that apply						Yes – please check all that apply			
		☐ Signature page must be printed and mailed in ☐ Family documentation must be mailed (i.e., income documentation) ☐ Electronic signature is required					☐ Signature page must be printed and mailed in ☐ Family documentation must be mailed (i.e., income documentation) ☐ Electronic signature is required ☐ No Signature is required			
Does your program		No				x	No			

	SCHIP Medicaid Expansion Program		Separate Child Health Program	
require a face-to-face interview during initial application		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?		No	x	No
		Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6		Yes Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6
	specify number of months		specify number of months	
Does your program provides period of continuous coverage <u>regardless of income changes?</u>		No		No
		Yes	x	Yes
	specify number of months		specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
			If he or she moved out of state or got other comprehensive health insurance	
Does your program require premiums or an enrollment fee?		No		No
		Yes	<u>x</u>	Yes
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below	
			$50 for one child; $100 for two or more	
Does your program impose copayments or coinsurance?		No		No
		Yes	**x**	Yes
Does your program require an assets test?		No	x	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
Is a preprinted renewal form sent prior to eligibility expiring?		No		No
	Yes, we send out form to family with their information precompleted and		Yes, we send out form to family with their information precompleted and	
		ask for confirmation	x	ask for confirmation and signature
		do not require a response unless income or other circumstances have changed		do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs? [x] Yes [ ] No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? [x] Yes [ ] No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)			x	
b) Application			x	
c) Benefit structure				x
d) Cost sharing structure or collection process				x
e) Crowd out policies			x	
f) Delivery system				x
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)				x
h) Eligibility levels / target population				x
i) Eligibility redetermination process				x
j) Enrollment process for health plan selection				x
k) Family coverage				x
l) Outreach				x
m) Premium assistance				x
n) Waiver populations (funded under title XXI)				x
Parents				x
Pregnant women				x
Childless adults				x
o) Other – please specify				
a. _____				
b. _____				
c. _____				

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	An additional layer of protection was added by the NC General Assembly as part of its Patients Rights Act
b) Application	The application was updated based on information gathered through focus groups, test marketing and readability testing as part of our continuous quality improvement process
c) Benefit structure	
d) Cost sharing structure or collection process	
e) Crowd out policies	The requirement that a child be uninsured for two months before being able to apply for the program was dropped. It was found to have no impact on children enrolling in the program. In the first eight months after being dropped (during which time 27,000 new children were enrolled in the program) 32 applications took advantage of this change. All the rest were long-term uninsured or Medicaid graduates.
f) Delivery system	
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
h) Eligibility levels / target population	
i) Eligibility redetermination process	
j) Enrollment process for health plan selection	
k) Family coverage	
l) Outreach	
m) Premium assistance	
n) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
o) Other – please specify	
a.	
b.	
c.	

SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program and if the strategic objective listed is new/revised or continuing.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Please include the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		
New/revised _____ Continuing __X___ To enroll as many children as possible that can be covered within available funds	To enroll up to 82,000 children in NC Health Choice	Data Sources: Use of the 7385 report measuring numbers of children enrolled as of "pull night" (four business days from the end of each month. Methodology: Compare the numbers and percentage of growth Progress summary: Once the program was reopened from the enrollment freeze on October 8, 2001 (51,000 children) enrollment growth proceeded at a rate of 5% per month until the October 2002 report reached 85,398. The goal was surpassed and an expected 2nd freeze in new enrollment was averted at the last minute by acting of the NC General Assembly
New/revised _____ Continuing _x____ To encourage reenrollment in the program	To reduce the percentage of those failing to reenroll in NC Health Choice	Data Sources: Special Reenrollment Reports Methodology: Those failing to reenroll are coded by cause (or no cause if cause is unknown), information is fed into computer system and two reports generated monthly one prior to ten day grace period, one post ten day grace period. Progress summary: Using the post ten day grace period as a measure, rate of drop out from the program declined dramatically after the enrollment freeze was instituted. Prior to the freeze, the percentage of those reenrolling who were eligible was 43.9%. During the reporting period the percentage of those reenrolling who were eligible was 58.1%. During the months immediately following the freeze, ranges of enrollment reached highs of 66%. Consistently some 20% of those who dropped off the program, however, enrolled in Medicaid and so did not become uninsured.
Objectives Related to SCHIP Enrollment (see above)		
New/revised _____ Continuing _x____ To maintain program		Data Sources: Blue Cross Blue Shield membership records Methodology: Progress Summary: Membership rose 16 percent above that of FFY 2001 while payments per member per month increased slightly. The largest segment of children were ages 6-12 at an average of 38,698 out of an average overall enrollment of 79,362—about half the enrollment; male/female ratio fairly evenly divided with slightly more males; ethnicity breakout echoing overall population.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised _____ Continuing _____		Data Sources: Methodology: Progress Summary:
Objectives Related to Increasing Medicaid Enrollment		
New/revised _____ Continuing __X___ To enroll the "woodwork" children	To continue to see Medicaid growth as S-CHIP grows.	Data Sources:The 7385 report of pull night (see above) Methodology: Ttake the SOBRA (MIC) children from the beginning of the reporting period and compare them to those at the end of the reporting period. Point in time, one portion of children on Medicaid. Progress Summary During this reporting period we increased Medicaid children by 26,913
New/revised _____ Continuing _____		Data Sources: Methodology: Progress Summary:
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
New/revised _____ Continuing __X___ To assure that enrolled children have access to a health provider	Using Blue Cross Blue Shield claims and utilization data to assure that children are using providers	Data Sources:Blue Cross/Blue ShieldClaims Methodology: Utilization study Progress Summary: Inpatient utilization decreased slightly during FY 2002. Respiratory disease accounted for close to 20 percent of all admissions. Injury and poisoning, digestive diseases, mental disorders and endocrine diseases each accounted for another 10 percent of admissions Utliization was also below the norm in hospital outpatient and ambulatory surgery settings. Emergency utilization exceeded the norm—non-urgent and urgent utilization rates were well above the norms while emergent was below the norm. Office visits decreased slightly – a decrease in visits to primary care providers while visits to specialists remained steady. (Please see attached report)
New/revised _____ Continuing _____		Data Sources: Methodology: Progress Summary:
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
New/revised _____ Continuing ___X__	To increase the percentage of well child visits	Data Sources: Blue Cross Blue Shield Claims Methodology: Utilization study Progress Summary: Although the group decreased its utilization of primary care sites, the top diagnosis at 19 percent was for health supervision of infant or child.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised _____ Continuing _____		Data Sources: Methodology: Progress Summary:
Other Objectives		
New/revised _____ Continuing _____		Data Sources: Methodology: Progress Summary
New/revised _____ Continuing _____		Data Sources: Methodology: Progress Summary:

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found? We have run selected parent satisfaction surveys and have kept in touch with researchers who have conducted focus groups and other studies. We have found an overwhelming level of satisfaction among parents of members. In addition, the Providers Task Force maintains connections with the membership organizations of that group. By and large, providers across the state are deeply satisfied with the program and encourage their fellows and patients to participate.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available? We are currently engaged in redesigning our program, an action required by inadequate funding. Among the hoped for outcomes will be some mechanism to establish care management as a component part of the entire program. With this, we hope to be able to reduce unnecessary trips to the emergency room, to teach patients better asthma control and to take other steps. We will redesign our evaluation tools as part of our program redesign. At the moment a study is being completed comparing care for children with special needs among Medicaid, NC Health Choice and the State Employees Health Plan. We will forward a copy to CMS as soon as it is released by the researchers.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found? Preliminary reports from the special needs survey indicates that access to care for NC Health Choice participants is very good.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings.

Attached are two reports:
The Blue Cross Blue Shield Annual Utliization Report that describes the use of the program by members
The Institute of Medicine Report on NC Health Choice which recommends changes in the program.

The following abstract reflects information requested in numbers 1-4:

Staff from the Cecil G. Sheps Center for Health Services Research, under contract with the Women's and Children's Health Section of the North Carolina Division of Public Health, surveyed parents of children with special health care needs in the state of North Carolina in the summer and fall of 2001. The stratified study sample included children in three insurance groups, Medicaid, NC Health Choice (NCHC), and the State Employees' Health Plan (SEHP), and five diagnosis groups, one of which was asthma (other groups being other chronic disease, developmental delay, mental health conditions, and ADD/ADHD). The study was not designed to focus specifically on children with asthma but many of the findings directly relate to these children and are reported here.

The focus of the study was assessment of the ability of NC Health Choice to meet the needs of children with special health care needs. The inclusion of samples of Medicaid and SEHP children allowed comparison of the experience of NCHC children with that of children on another public insurance program and that of children covered by a large employment-based insurance program. The SEHP insures a large number of children of State employees in various government departments, public schools, and universities. Although some State employees in lower income brackets may actually qualify for North Carolina Health Choice, average family income in this group of insured children is higher than that of children in the other insurance groups.

Using a written survey completed by parents of children with special health care needs identified through ICD-9 codes on insurance claims, the study examines the health care and ancillary services that NC parents report that their children require. It also examines which reported health care needs are not being met, and what barriers limit access to needed services. Descriptive statistics and qualitative analysis of parental reports are combined to assess the extent to which parents of children with special needs in each of the three health plans are able to obtain care for their children.

Children were selected as part of the asthma subsample if they had an insurance claim in recent months with an ICD-9 code in the 493 group. Surveys were sent to the parents of 250 children in the asthma diagnosis group in each of the three insurance groups (750 total). Of these, 442 usable surveys were returned.

RESULTS

Health status: ***Parents were asked to describe their child's health as excellent, good, fair, or poor. Parents of children with asthma were less likely to report that their child is in excellent health compared with parents of children in the other four diagnosis groups.***

School services: ***Overall, 34% of children who attend school or day care reported that their child were reported by their parents to receive special services at school because of their health or developmental condition. Only half that many (17%) in the asthma group received school-based services. Among children in the asthma group, those covered by public insurance were significantly more likely to receive services at school (21% to 23%) compared to SEHP (9%).***

Access to Medical Care: *Reported access to medical care, both general and specialty care, was relatively good for all children in the sample, including children in the asthma group who were insured by NCHC. Few children had no provider for general medical care.*

In order to assess unmet need for general care, parents were asked if there had been any time in the previous six months when their child had needed general medical care but could not get it. Overall, 6.5% of parents reported having difficulty getting general medical care for their child in the previous six months. Only 5% of parents of children on NCHC reported unmet need for general medical care which was similar to unmet need for general medical care reported for to SEHP children, but better than for Medicaid children, 10% of whom needed care they could not get. The most frequently cited reason for unmet need for general medical care for NCHC children was provider office hours. For children in the NCHC insurance group, there were no significant differences in unmet need across diagnosis groups.

Among all children, almost half (45%) received care from one or more medical specialists, with significant differences across both health plans and diagnosis groups. SEHP children were significantly more likely to receive medical specialist care (53%) compared to Medicaid children (41%) and NCHC children (42%). Across all insurance groups, only 39% of children in the asthma group saw a specialist. Among those children, 69% received specialty care in a private office, 14% in a hospital clinic, and the remainder from public providers, multiple care sites, or at sites of care that could not be classified. Overall, 6% of NCHC parents reported that their child had an unmet need for specialist care in the last six months.

Parents of NCHC children were less likely than SEHP parents to report that their child receive care from a medical specialist despite the fact that SEHP children were reported by their parents to be the healthiest of the three insurance groups on several measures. The greater use of specialty care by SEHP children may be due less to greater need than it is to parental ability to advocate for their child and obtain that care despite referral and other barriers, higher family income, and flexibility in the parent's work schedule.

Emergency Room: Parents were asked if they had taken their child to the emergency room (ER) in the previous six months, and, if so, how many times. Overall, 24% of children had made at least one ER visit in the specified time frame. Children covered by Medicaid were the most likely to have used emergency room services (34%), followed by NCHC (25%) and SEHP (15%). Among diagnosis groups, children in the asthma group were most likely to have used the ER (35%).

Health care providers and insurers are particularly interested in the use of the emergency room as a marker of inadequate access to health care. Asthma is a condition that can be examined to assess how well individuals are getting disease treatment and education to allow them to manage their disease on an outpatient basis and avoid costly hospitalization and use of the emergency room. Although hospitalization was not assessed in this study, use of the ER by these children with asthma can be described.

As noted above, children selected for the study because they had an insurance claim for asthma were more likely than children in other diagnosis groups to have had an ER visit. Among children chosen because of their asthma diagnosis, those insured by NCHC were more likely than comparable children on SEHP to have had an ER visit (33% vs 25%) but less likely than comparable children on Medicaid (46%).

An ER visit was classified as asthma related if parents listed the reason for seeking care as asthma, reactive airway disease, or symptoms such as wheezing or difficulty breathing that might indicate asthma. This classification of an ER visit is likely conservative because asthma might be the underlying condition that prompts a parent to seek ER care for a child with other respiratory problems. Among the parents of children in the asthma diagnosis group who responded that their child had made an ER visit within the specified timeframe, 51% of the visits were considered to be asthma related using the above criteria. Children in other diagnosis groups also made asthma related visits, ranging from 11% of children in the ADD/ADHD group to 5% of children in the mental health group.

In general, asthma was a large component of emergency room use reported by this group of parents. Eighteen percent (18%) of parents, regardless of the child's diagnosis group, reported that their child's most recent emergency room visit was for asthma. Two-thirds of this use was by children in the asthma diagnosis group, but one-third was not, supporting the supposition that many of the children in our sample have multiple health problems, and could have been in more than one diagnosis group.

Prescription drugs: Ninety-four percent (94%) of children in the asthma diagnosis group had been given a prescription for medicine at least once in the previous six months. Among all children in the sample who were prescribed medication, 6% were unable to get the prescription filled and the percent with unmet medication needs did not differ significantly by insurance plan. The most common reason children enrolled in NCHC could not get the prescription filled was that their insurance would not pay for the particular medicine the child needed.

Medical equipment and supplies: Parents of 41% of children in the asthma diagnosis group reported that their child had needed special medical equipment or supplies in the previous six months. Children on Medicaid were more likely to have needed equipment or supplies, but NCHC children were less likely to have gotten their needs met. One-fourth of NCHC parents reported unmet need in this area. The most frequently reported barrier to receipt of the needed items was that NCHC did not cover the equipment the child needed (64% of those with need). This finding is of concern given the fact that most equipment and supplies are covered under the plan. Based on comments made by parents in another part of the survey it appears that many of the problems may stem from either the need for pre-approval for some items or policies of equipment and/or supply vendors that require upfront payment by the parent.

Even though parents are later reimbursed by NCHC for their out-of-pocket expenses, some reported that coming up with the necessary funds is difficult.

Like most questions in the survey that asked parents to recall health care needs, the time frame specified for needing equipment and supplies was the past six months. This question likely underestimates the need for special equipment by children with special health care needs, particularly durable medical equipment that does not need frequent replacement or replenishment. The types of medical equipment or supplies reported as needed but not obtained frequently were for care for asthma and diabetes. Among the 96 parents from all insurance groups reporting problems, one-fourth said that the type of supply or equipment their child needed but could not get was for asthma care, usually a nebulizer.

Respiratory therapy: Children with asthma may need other types of care such as respiratory therapy. Across all diagnosis and insurance groups, 13% of children were reported to have needed respiratory therapy services in the previous six months, with 12% of NCHC children having such need (compared with 19% of Medicaid and 9% of SEHP). As would be expected, children in the asthma diagnosis group were the most likely to have needed respiratory therapy (43%). There were only 13 children total who could not get all the respiratory therapy they needed, but six of the thirteen children were in the asthma diagnosis group. The primary reasons the child could not get all respiratory therapy services needed was that insurance would not pay for the care or the physician would not refer the child for care.

See also

Blue Cross Blue Shield Utilization report attached. Overview of the rate of utilization of different aspects of the program.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

ENROLLMENT

1. Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).

_____	SCHIP Medicaid Expansion Program (SEDS form 64.21E)	_____	Separate Child Health Program (SEDS form 21E) 126,090

2. Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.

   Because of the economic downturn, it is impossible to show evidence of a reduction in uninsured, low-income children. One can only assume that without the program there would have been an additional 146,000 more uninsured children in the state

(States with only a SCHIP Medicaid Expansion Program, please skip to #4)

3. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

   99,439 (since program inception); 26,913 (during reporting period)

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?

   Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

_____	No, skip to the Outreach subsection, below		
X _____	Yes, please provide your new baseline 100,000	_____	And continue on to question 5

5. On which source does your State currently base its baseline estimate of uninsured children?

   _____ The March supplement to the Current Population Survey (CPS)

   _____ A State-specific survey

   x _____ A statistically adjusted CPS

   _____ Another appropriate source

   A. What was the justification for adopting a different methodology? Because it is impossible to determine the numbers of uninsured children with current CPS numbers which continue to report fewer children in the income category than are already enrolled in Medicaid, we have continued to use actual numbers of enrollees as an adjustment to CPS numbers. Looking at the range of possibilities we have selected 100,000 and have decided to adjust up by 5,000 annually. This is based in part on the maximum federal dollars available to North Carolina through Title XXI.

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.) The State of North Carolina asked the Cecil G. Sheps Center at UNC-Chapel Hill to analyze and evaluate the numbers of uninsured children in the state and to assist in crafting a reasonable estimate of uninsured children.

To try to address these problems, staff from the Cecil G. Sheps Center for Health Services Research tried to develop estimates using actual state-level data (for example, the actual numbers of children enrolled in NC Health Choice and Medicaid).[1] CPS data was only used when other state-level data was unavailable.

	<1 (185-200%)	1-5 (133-200%)	6-18 (100-200%)	TOTAL
Number of children Data: Office of State Planning population estimates for different ages, multiplied by the number of children in different income cells (from CPS)	1,576	41,379	121,952	**164,907**
Children currently on NCHC (Data: NC Health Choice actual enrollment data)	*105*	*19,304*	*70,621*	***90,030***
Children on Medicaid (Data: Division of Medical Assistance actual enrollment data)	*838*	*207*	*4,060*	***5,105***
Remainder (Children with unknown insurance status—i.e., can be privately insured, covered by CHAMPUS, uninsured)	633	21,868	47,271	**69,772**
Percent uninsured (Data: Used CPS to generate the percent of children in different income categories that are uninsured)	*10.34%*	*20.36%*	*22.02%*	
Number uninsured	65	4,452	10,409	**14,927**
Total NCHC Potentials				**104,957**

Based on this analysis, the Sheps Center estimated that there are currently approximately 105,000 children with incomes below 200% of the federal poverty guidelines that could be eligible for NC Health Choice. Of this, about 90,000 are already covered, leaving approximately 15,000 uninsured eligible children who have not enrolled in the program.[2] Determining the number of children who may be eligible over the next five years is more difficult, as the growth in the program will be affected by overall population growth and changes in the economy and the cost of private health insurance coverage.

[1] Rebecca Slifkin, Cecil G. Sheps Center for Health Services Research, Presentation to NC IOM Task Force on NC Health Choice. November 2, 2002.

[2] Using the CPS data, the Census estimated that there are approximately 155,000 children who could be eligible for NC Health Choice—however, CPS historically undercounts the number of children on Medicaid so these estimates are probably overestimates of the numbers of uninsured children.

According to the Office of State Planning, growth in the total number of children is expected to grow approximately 1.5% per year.[3] In addition, some additional children may qualify if families lose some of their income through reduced hours, or if premiums get too high to be able to afford private coverage.[4] Given the uncertainty in the economy, and the expected increases in private insurance premiums, the Task Force decided to estimate a growth of approximately 5,000 eligibles each year for the next five years.

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?
If the state had not changed its baseline we would have enrolled 128% of our original estimated number of total uninsured children in North Carolina. As to our original baseline of 30,000 children annually until some 68,000 children (of the estimated 72,000 uninsured) had been enrolled. We would have enrolled 310% of our original baseline.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

- With the reopening of enrollment after a 9-month freeze, activities during the first 6 months of this Federal fiscal year were focused on reactivation of State and local coalition outreach activities, and communication with a broad array of health and social service agencies, child advocacy organizations, professional associations and community-based organizations.

  - Communicated through letters, newsletters, and list serves to explain the reactivation of enrollment for children on the waiting list; to provide programmatic updates; to suggest how various groups could continue to support our outreach, enrollment, and re-enrollment efforts; and to provide new catalogs (& web site access) for ordering outreach materials and application forms.
  - Restructured and revitalized the State Health Check / Health Choice and *Covering Kids* Coalition.
  - Updated our local coalition database & began development of a list serve.
  - Encouraged local coalitions to institutionalize their structures, in some cases by linking with other existing, ongoing coalitions (e.g. Healthy Carolinians; Interagency Councils; Child Fatality Prevention Teams; etc.).
  - Encouraged Health Check Coordinators (case managers) to target outreach through schools; through Food Banks, unemployment offices and other places families turn during an economic downturn; by offering application assistance during plant closings / layoffs; by deputizing them to assist with re-enrollment; and by recruiting community service providers to assist with outreach /enrollment / and re-enrollment efforts.
  - Encouraged School-Based and School-Linked Health Centers to mount an annual campaign to enroll & re-enroll their students focusing on the "back to school" time period.

- The Division of Medical Assistance, Division of Public Health, our Campaign Office and our RWJ *Covering Kids* Project have collaborated on the development of family-friendly enrollment and re-enrollment materials.

  - A new Health Check / Health Choice Enrollment Application was developed which is graphically designed, family-friendly and focus-tested. It incorporates recent policy changes and Federal requirements.

[4] If parents lose their jobs altogether, the family income may be reduced enough to have their children qualify for Medicaid.

- Refinements to the Re-enrollment Process were introduced based on input from focus groups with Health Check and Health Choice families. Based on their input, a re-enrollment post card has been developed, the Re-enrollment Form is being revised, a family-friendly reminder letter was developed for those who fail to respond timely, and envelopes containing these materials bear the Health Check/Health Choice logo and message regarding the importance of the mailing.
- Administrative letters sent to families by the Division of Medical Assistance are being revised to be more family-friendly (incorporating graphics and clearer language).

. Through a collaborative effort, the NC Pediatric Society Foundation, submitted a RWJ *Covering Kids and Families* Grant Proposal in January 2002. State staff and our state coalition participated in the development of the Request for Proposal process for local partners and in work plan development. The grant was funded effective October 1, 2002. New strategies are proposed, including:

- "Learning collaboratives" (phone-in conference calls) - to share experiences and develop an active, ongoing process for learning and sharing of "best practices."
- Institutionalizing "back-to-school" outreach / enrollment efforts.
- Institutionalizing outreach through child care centers, utilizing a modified "Annual Child Care Immunization Report", outreach by Child Care Health Consultants, modifying childcare facility regulations, etc.
- Many other strategies are proposed.

- Due to funding constraints, our NC Family Health Resource Line, which serves as both our Title V and Health Check / Health Choice Toll-Free Line was moved to a different sponsoring organization (UNC-Chapel Hill School of Public Health) as of August, 2002. Orientation and training of new staff occurred and training, information and resource/referral manuals and databases are being updated. The line retained its original name, toll-free number, bilingual capacity, and hours of operation.

- New materials and a web site were developed to support our Statewide Health Check / Health Choice Outreach / Education Campaign. In addition, a Health Check / Health Choice Radio Campaign targeting the Spanish-speaking population was run in June 2002, and two new infomercials were developed for use when families are "on-hold" to talk with staff of the NC Family Health Resource Line.

  - A new Health Check / Health Choice Family-Friendly Web Site was developed which links to the application form, benefits booklets, and other critical information. (www.NCHealthyStart.org).
  - Health Check / Health Choice Photo Refrigerator Magnets (English and Spanish) were developed / distributed with the toll-free number.
  - "Ask me about Health Check / Health Choice" buttons were produced (in English and Spanish) for use by health care providers and their staff. Urgent care facilities, emergency room physicians and hospitals with emergency departments were targeted in the distribution process.
  - A brochure for teachers and school staff, developed through *Covering Kids*, was printed and distributed.
  - A new more family-friendly, graphically-designed flyer / fact sheet was developed.
  - An updated catalog was published to assist local agencies/organizations in their ordering of Health Check / Health Choice outreach materials and application forms.

  - In anticipation of a second *threatened* freeze on new enrollment, a coalition letter was developed and distributed. This mailing included a "Freeze Question and Answer Tool", a copy of the letter that was mailed to parents of current Health Choice enrollees about the pending freeze, and findings from a Sheps study on "The North Carolina Health Choice Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families." (Note: The anticipated freeze was called off after state legislators passed a bill that allowed the transfer of $5 million into the Health Choice Program. A NC Institute of Medicine Task Force was convened to advise the NC General Assembly on how to "both address the health needs of the children of the state and meet the very real financial realities.") A follow-up local coalition newsletter provided an update on the status of the program.

- A new outreach / education campaign is being developed to encourage families to link to a medical home, appropriately seek preventive services and utilize primary care providers.

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

- Outreach by local DSS staff - as they come in contact with families applying for various social service programs.
- Outreach through health care providers and public / private health care facilities (particularly publicly-funded clinics).
- Outreach through schools - "back to school" efforts; outreach through school nurses, coaches, teachers / counselors; PTAs; Open Houses; School-Based and School-Linked Health Centers.
- Outreach through child care facilities utilizing Child Care Health Consultants and adapting regulatory requirements holds promise in institutionalizing outreach to the pre-school population.
- Targeted community-based outreach to special populations (including children with special health care needs and minority populations) focusing on the agencies and organizations that serve these populations. (See response to Question #3).
- Media coverage, to support / enhance the impact of all of the above efforts.
- And, most importantly, a broad-based, committed local coalition that is supported by staff who can follow through.

Effectiveness has been measured utilizing the following methods:

- Family survey data from the Cecil G. Sheps Center for Health Services Research
- Lessons learned from our RWJ *Covering Kids* Project (as a result of their evaluation efforts).
- Data collected from the NC Family Health Resource Line (our toll-free line for Health Check / Health Choice).
- Anecdotal data from focus groups of Health Check / Health Choice parents.
- Health Check / Health Choice enrollment and re-enrollment data from the Division of Medical Assistance.

3. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness? Outreach strategies designed and implemented by and for specific minority groups appear to have had the greatest impact.

Through our Duke Endowment Health Choice Minority Outreach Grant, we targeted outreach to African American, Hispanic / Latino and American Indian communities. From those projects, we learned that outreach is most successfully accomplished when the message is delivered personally from someone they trust. The different projects utilized door to door canvassing, home visiting, and outreach to community agencies, organizations, health care providers, businesses, media and churches that specifically serve the population being targeted. The *Covering Kids* Projects have also identified the above lessons learned from targeting minority and immigrant populations in their counties.

Outreach and enrollment materials must be translated into Spanish and interpreter services must be made available at critical sites where enrollment occurs and where health care services are provided. Toward that end, we continue to maintain a database of Spanish-speaking contacts at the county-level to whom the NC Family Health Resource Line may refer Spanish-speaking callers who wish to enroll their children. The Line also maintains a database of free and / or sliding fee scale clinics to whom they may refer immigrant families who do not qualify for Health Check / Health Choice due to the five-year waiting period for Legal Permanent Residents.

According to the Sheps Family Survey, Hispanic/Latino children were much more likely to be reached through the public health department compared to other children (58% compared to 24% of whites and 21% of blacks). They were also much less likely to hear about NC Health Choice from the Department of Social Services (38% compared to 62% of whites and 68% of blacks).

The Sheps Survey also revealed that rural residents were more likely than urban residents to report hearing about the program from another health care provider (13% versus 6%) and from billboards (12% versus 6%).

For children living in rural areas, having local grassroots outreach coalitions was a key factor in our success. Outreach efforts were intense, multi-faceted and tailored to the communities. Some of our most rural counties in North Carolina experienced early success in enrolling children and most achieved (or exceeded) their target goal of enrolling all of their *projected* potentially eligible population. We now know that our CPS data undercounted our potentially eligible population.

- Data Sources: Report for The Duke Endowment Project; family survey data from the Cecil G. Sheps Center for Health Services Research; "lessons learned" from our RWJ *Covering Kids* Project; enrollment / re-enrollment data from the Division of Medical Assistance.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

All States must complete the following 3 questions

1. Describe how substitution of coverage is monitored and measured. North Carolina codes every application as to whether or not it is eligible to be considered retroactively to the first date of the month of application or proactively, after insurance has been dropped. We electronically monitor how many children have dropped insurance in order to enroll in NC Health Choice for Children.

2. Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP? During the first few months of calendar 2001, when the state's waiting period had been eliminated 27,000 new children enrolled in the program. Of these, only 32 applications were approved pending dropping of health insurance. So the percentage of application is .01%. As a result of numbers like these, we have concluded that there is no problem with substitution and that our program works very well.

3. At the time of application, what percent of applicants are found to have insurance? See above.

States with separate child health programs over 200% of FPL must complete question 4

4. Identify your substitution prevention provisions (waiting periods, etc.).

States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.

5. Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

States with waiting period requirements must complete question 6. (This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. Identify any exceptions to your waiting period requirement.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain. Yes, same verification. No interviews required.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain. In both Medicaid and SCHIP children are enrolled for a 12 month period of eligibility. When it is time for renewal, the eligibility worker looks at family income and enrolls the child in the program that matches family income level. Some 60-80 percent of the families in NC Health Choice for Children are Medicaid graduates. During

the enrollment freeze we discovered that a large number of our Medicaid graduates were kept from service.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain No, Medicaid has a preferred provider network. NC Health Choice is offered as an any willing provider indemnity program.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? *Check all that apply*.

x Follow-up by caseworkers/outreach workers

x Renewal reminder notices to all families, *specify how many notices and when notified*
Four from the state. State notifications include at the beginning of the 11th month of eligibility – a letter, followed by postcard notifying the family that the renewal application is on its way, followed by a notice allowing the family a ten day grace period. In addition each child has eligibility dates printed on the front of the cards. All providers have been asked to remind patients of upcoming reenrollment times, all pharmacists as well. Counties are urged to make phone calls, write additional letters, etc.

____ Targeted mailing to selected populations, *specify population* _____

____ Information campaigns

x Simplification of re-enrollment process, *please describe* _____

x Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe* _____

____ Other, *please explain* _____

2. Which of the above measures have been effective? Describe the data source and method used to derive this information. Once the freeze in new enrollments occurred, families became much more diligent about the reenrollment process.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?) If so, describe the data source and method used to derive this information.
Yes. This is developed from our eligibility files.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found? Yes, failure to pay enrollment fees have consistently been the leading reason for failure to enroll in the program.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found? No.

FAMILY COVERAGE PROGRAM UNDER TITLE XXI

1. Does your State offer family coverage through a family coverage waiver as described in 42 CFR §457.1010?

____ Yes, briefly describe program below and continue on to question 2.

x No, skip to the Premium Assistance Subsection.

2. Identify the total State expenditures for family coverage during the reporting period.

3. Identify the total number of children and adults covered by family coverage during the reporting period. (Note: If adults are covered incidentally they should not be included in this data.)

_____ Number of adults ever enrolled during the reporting period

_____ Number of children ever enrolled during the reporting period

4. What do you estimate is the impact of family coverage on enrollment, retention, and access to care of children?

5. How do you monitor cost effectiveness of coverage? What have you found?

PREMIUM ASSISTANCE PROGRAM UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program through SCHIP?
   Note: States with family coverage waivers that use premium assistance should complete the Family Coverage Program subsection. States that do not have a family coverage waiver and that offer premium assistance, as part of the approved SCHIP State Plan should complete this subsection and not the previous subsection.

   ____ Yes, briefly describe your program below and continue on to question 2.

   __x__ No, skip to Section IV.

2. What benefit package does your state use? e.g., benchmark, benchmark equivalent, or secretary approved

3. Does your state provide wrap-around coverage for benefits?

4. Identify the total number of children and adults enrolled in your premium assistance SCHIP program during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

   _____ Number of adults ever enrolled during the reporting period

   _____ Number of children ever enrolled during the reporting period

5. Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program.

6. Indicate the effect of your premium assistance program on access to coverage.

7. What do you estimate is the impact of premium assistance on enrollment and retention of children?

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. *Note: This reporting period = Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02). If you have a combination program you need only submit one budget; programs do not need to be reported separately.*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Insurance payments	113,586,056	**172,390,171**	**192,834,560**
Managed Care			
Per member/Per month rate @ # of eligibles	120.84@79549	141.99@100,000	159.03@100,000
Fee for Service			
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	**$**	**$**	**$**
Administration Costs			
Personnel	200,000	206,491	212,846
General Administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing	5.969,880	6,686,266	7,488,617
Outreach/Marketing costs	621,353	621.353	621,353
Other	1,347,235	1,347,235	1,347,235
Total Administration Costs	8127468	8,861,345	8,333,816
10% Administrative Cap (net benefit costs ÷ 9)	13,849,612	**19,154,463**	**21,426,062**
Federal Title XXI Share	89,754,127.25	**133,401,115.78**	**148,059,924.74**
State Share	32,502,850.90	**47,850,400.24**	**53,108,451.26**
TOTAL COSTS OF APPROVED SCHIP PLAN	121,733,524	**181,251,516**	**201,168,376**

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- **x** County/local funds
- _____ Employer contributions
- **x** Foundation grants
- _____ Private donations (such as United Way, sponsorship)
- _____ Other (specify)

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled your demonstration SCHIP program during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration waiver is on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. *Note: This reporting period (Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #1			
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #2			
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			
Total Benefit Costs			
(Offsetting Beneficiary Cost Sharing Payments)			
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			
Administration Costs			
Personnel			
General Administration			
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			
Federal Title XXI Share			
State Share			
TOTAL COSTS OF DEMONSTRATION			

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

The last two years have been economically rough in North Carolina. This was one of the first states to be hit by the economic downturn. As a result , the state budget for the past three years has been suffering from billion dollar shortfalls. At the same time, businesses have been paring back and closing. As always in times of economic stress, children feel the impact first. Employers have pared back insurance coverage to employee only, often either eliminating family coverage or pricing it out of the reach of workers. Some families whose breadwinners have lost their jobs and their benefits have found that COBRA costs are so high, they cannot afford coverage. Later when they find other employment they often find their children denied coverage for preexisting and often serious and costly conditions. Despite such a restrictive budget setting that for the first time the NC General Assembly failed to contribute any funds to state employee retirement and reduced employee benefits while increasing their costs, the General Assembly found some funds to prevent a second expected freeze in NC Health Choice, ordering it instead to stay open and asking the NC Institute of Medicine to study the program and make recommendations on the best way to modify it so that children could continue to be served.

2. During the reporting period, what has been the greatest challenge your program has experienced?

Attempting to manage the program with few tools to control program expansion. Without adequate measures of the numbers of children eligible, correctly predicting the demand for the program has been nothing short of impossible.

3. During the reporting period, what accomplishments have been achieved in your program?

The return from the freeze and enrolling eligible children, reestablishing trust in the program and assuring that it maintained that trust in difficult economic times.